

**Florida  
Power**  
CORPORATION

April 29, 1981  
#3N-81-145  
3-0-3-a-1  
CS-81-094



Mr. J. P. O'Reilly, Director  
U.S. Nuclear Regulatory Commission  
Office of Inspection & Enforcement  
101 Marietta St., Suite 3100  
Atlanta, GA 30303

Docket No. 50-302  
Licensee No. DPR-72  
LER No. 81-020/03L-0  
Crystal River Unit #3  
Occurrence Date:  
April 5, 1981

Dear Mr. O'Reilly:

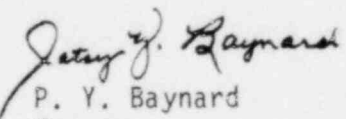
Enclosed please find Licensee Event Report 81-020/03L-0 and the attached supplementary information sheet, which are submitted in accordance with Technical Specification 6.9.1.9.b.

Should there be any questions, please contact us.

Very truly yours,

FLORIDA POWER CORPORATION

  
Nuclear Plant Manager

  
P. Y. Baynard  
Manager  
Nuclear Support Services

JC/rc

Attachments

810505 0517  
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## EXHIBIT A

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (C)

Tests, it was discovered that ES Subsystem A LPI Channel RC-4 would not reset with

Tests, it was discovered that ES Subsystem A LPI Channel RC-4 would not reset with

reset permissive. This created an event contrary to T.S. 3.3.2.1. Maintenance was

initiated and operability was restored at 0130 on 4/6/81. There was no effect upon

the health or safety of the general public. This is the first occurrence of RC-4

failing to reset and this is the nineteenth event reported under this Specification.

### CAUSE DESCRIPTION AND CORRECTIVE ACTIONS

The cause of this event is attributed to the failure of a mercury wetted relay in

the 500 psig bistable. The relay was repaired, reinstalled, and functionally

tested satisfactorily. No further corrective action is deemed necessary at this

time. The relay was Model No. HGS 2 MT 5105 in card No. 6621496-A1 of RC-4.

<sup>12</sup>Name of Preparer:

BUFILE (904) 795-6486

810505 0 528

(SEE ATTACHED SUPPLEMENTARY INFORMATION SHEET)

# SUPPLEMENTARY INFORMATION

Report No.: 50-302/81-020/03L-0

Facility: Crystal River Unit 3

Report Date: April 29, 1981

Occurrence Date: April 5, 1981

Identification of Occurrence:

Failure of A Channel to reset during surveillance testing of Engineered Safety Feature Actuation System contrary to Technical Specification 3.3.2.1.

Conditions Prior to Occurrence:

Mode 3 hot standby (0%)

Description of Occurrence:

At 2020 during performance of SP-130, Engineered Safeguards Monthly Functional Test, it was discovered that subsystem "A" low pressure injection channel RC-4 would not reset with reset permissive. Maintenance was initiated and operability was restored at 0130 on April 6, 1981.

Designation of Apparent Cause:

The cause of this event is attributed to the failure of a mercury wetted relay in the 500 psig trip bistable. The relay was Bailey Model No. HGS 2 MT 5105 installed in card No. 6621496-A1.

Analysis of Occurrence:

There was no effect upon the health or safety of the general public.

Corrective Action:

The relay was tapped to recombine the mercury, then reinstalled and functionally tested satisfactory. No further corrective action is deemed necessary at this time.

Failure Data:

This is the first occurrence of RC-4 failing to reset and this is the nineteenth event reported under this Specification.

/rc